Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST FORT WORTH
4355 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name
TWIN CITY FIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-06-3997-01

MFDR Date Received
JANUARY 23, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been processed incorrectly. We have found in this audit there is a discrepancy in regards to the appropriate reimbursement according to the Acute Care Inpatient Hospital Fee Guideline. This is considered a 'trauma' admit and can be exempt from the perdiem rates…Medicare would have allowed this facility $8871.75 for DRG 218. We are asking the allowable to be 140%-over-Medicare ($12420.45). This would leave a supplement payment of $9211.57 due at this time."

Amount in Dispute: $9211.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated September 13, 2012: "Please be advised that Qmedtrix has advised that they are continuing their review of the above dispute."

Response Submitted by: The Hartford

Respondent's Position Summary dated September 18, 2012: "Please be advised that Qmedtrix has advised that they are continuing their review of the above dispute. They advised a detailed explantion [sic] to follow recommending an additional $986.50 to be paid. We are requesting and extension until 9/21/12 for full documentation of such."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2005 through February 22, 2005	Inpatient Services	$9211.57	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Reimbursement according to the Texas medical fee guidelines.
   - C-The charges have been priced in accordance to a contract owner or accessed by a First Health company.
   - W1-WC state fee sched adjust. reimbursement according to the Texas medical fee guideline.
   - 193-Orignal payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time. Bill has been paid according to state fee guidelines or rules and regulations.
   - 16-WLCIM srvc lack info which is needed for adjudication, when medically necessary the following srvcs shall be reimbursed at cost to the hospital plush 10% per rule 134.401(c)(4)(A). [sic]
   - 45-Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to your fee for service contract with First Health.

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges Exceed Your Contracted/Legislated Fee Arrangement," and "C-The charges have been priced in accordance to a contract owner or accessed by a First Health company." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 823.02. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).

1. Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Medicare would have allowed this facility $8871.75 for DRG 218. We are asking the allowable to be 140%-over-Medicare ($12420.45). This would leave a supplement payment of $9211.57 due at this time."
   - The requestor does not discuss or explain how additional payment of $9211.57 would result in a fair and reasonable reimbursement.
   - The requestor did not discuss or explain how it determined that the 140% Medicare rate would yield a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor did not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee

charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		2/5/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.